CALIFORNIA'S HEALTH

WILTON L. HALVERSON, M.D.
DIRECTOR OF PUBLIC HEALTH

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ANN WILSON HAYNES, Editor
JEROME GROSSMAN, Assistant

A Plan For Health Center Construction In California*

A public health center is defined by the U. S. Public Health Service as "a publicly owned facility utilized by a local health unit for the provision of public health services, including related facilities, such as laboratories, clinics and administrative offices operated in connection with public health centers." If the jurisdiction of the local health unit covers a large area, it may be necessary to have additional offices in other towns, or even in different sections of the same city, in order to make health services available to all the population.

The term "auxiliary facility" is used to designate these branches of the public health center. For example, one auxiliary unit may contain offices for public health nurses and sanitarians as well as space for clinics. In another community, only clinic space may be needed and the other services may be rendered from the public health center. In counties with small populations, these auxiliary facilities may be planned in combination with emergency medical and hospital facilities.

The most important factor in the development of a state-wide health center plan, which will provide public health services to all the people of the State, is the desire of the people in local communities to provide themselves with local health units and programs designed to meet local needs. At the present time, local health programs of varying degrees of adequacy are in operation in about 60 percent of the State's area, and provide services to about 95 percent of the State's population. However, 25 counties are without local health services of any kind and will need facilities when such programs are developed. The administrative and organizational plan of these units will vary in different areas of the State, depending upon the political subdivisions under the jurisdiction of the newly organized health departments. It is possible that some existing local health departments may enlarge the areas they serve. If so, additional facilities, both health centers and auxiliary facilities, will probably be needed to accommodate the expanded services and additional personnel required to render these services.

The regulations established by the U. S. Public Health Service under Public Law 725 state that the maximum number of public health centers which may be provided in a state with federal aid, counting those already existing, as well as those provided with aid under the act, shall not exceed one per 30,000 population. The California State Department of Public Health recommends that, in order to make the most effective use of tax funds utilized to support local health programs, the population within the jurisdiction of each local health department should exceed 40,000 and it is preferable to include at least 50,000 persons. Therefore it is necessary in some areas of the State that two or more counties with small populations combine to form one health jurisdiction in order to develop an economically sound and administratively practical local health program. Such cooperative arrangements between counties may be established by agreement, as has been done by Sutter and Yuba Counties, or by forming a health district under the Local Health District Act as has been done by San Joaquin County.

*An excerpt from Chapter II of a forthcoming report, *Hospital Facilities in California, Revised Report*, to be issued by the California State Department of Public Health. Chapter I of this report, "A State-wide Plan for Hospital Construction in California," appeared in the January 31, 1948, issue of *California's Health*.

In counties with small populations the health department may be planned in conjunction with the hospital to avoid duplication of buildings, equipment and services. Each unit may be a separate administrative entity or both the preventive and curative medical services in the community may be combined under one administration. This latter plan is most practical when the services of the local health department are administered in conjunction with a county or district hospital.

The plan for health centers and auxiliary facilities suggested in this report does not include any specific plan for the administrative organization of public health programs, or recommendations as to particular combinations of political subdivisions. The locations which are recommended for public health centers and auxiliary facilities throughout the State have been chosen after careful consideration of the distribution of the population, the routes of transportation and commerce, and the location from which full-time health services could be provided most effectively. In the future it may become advisable to change the location of some of these facilities to meet changing conditions.

The health center facilities recommended for California are listed geographically beginning with the northern part of the State.

PROPOSED PUBLIC HEALTH CENTER AND AUXILIARY FACILITIES
California, 1948

	County	Estimated population*	Proposed facility	
			Location	Type
1	Del Norte	5,000	Crescent City	Auxiliary
2	Humboldt	48,900	Eureka	Health Center
			Arcata	Auxiliary
			Fortuna	Auxiliary
3	Trinity	4,300	Weaverville	Auxiliary
4	Shasta	32,200	Redding	Health Center
			Fall River Mills	Auxiliary
5	Siskiyou	33,800	Yreka	Health Center
			Weed	Auxiliary
			Tule Lake	Auxiliary
6	Modoc	9,300	Alturas	Auxiliary
7	Lassen	15,500	Susanville	Health Center
8	Butte	45,800	Chico	Health Center
			Oroville	Auxiliary
			Gridley	Auxiliary
9	Plumas	12,300	Portola	Auxiliary
			Quincy	Auxiliary
10	Glenn	15,200	Willows	Health Center
11	Tehama	15,300	Red Bluff	Auxiliary
12	Colusa	10,400	Colusa	Auxiliary
13	Mendocino	35,300	Ukiah	Health Center
			Fort Bragg	Auxiliary
			Willits	Auxiliary
14	Lake	8,700	Lakeport	Auxiliary
15-16	Sutter & Yuba	42,800	Marysville	Health Center
			Yuba City	Auxiliary
17	Placer	32,800	Auburn	Health Center
			Roseville	Auxiliary
			Truckee	Auxiliary
18	Nevada	20,600	Grass Valley	Health Center
19	Sierra	3,200	No construction recommended	
20	El Dorado	14,100	Placerville	Health Center or Auxiliary Center
21	Tuolumne	11,700	Sonora	Auxiliary
22	Amador	9,600	Jackson	Auxiliary
23	Calaveras	8,800	San Andreas	Auxiliary
24	Mariposa	6,000	Mariposa	Auxiliary
25	Sonoma	81,900	Santa Rosa	Health Center
			Petaluma	Auxiliary
			Healdsburg	Auxiliary
			Sonoma	Auxiliary
			Sebastopol	Auxiliary

PROPOSED PUBLIC HEALTH CENTER AND AUXILIARY FACILITIES—Continued
California, 1948

	County	Estimated population*	Proposed facility	
			Location	Type
26	Marin	69,500	San Rafael	Health Center
			Sausalito	Auxiliary
			Inverness	Auxiliary
			Novato	Auxiliary
27	Napa	51,100	Napa	Health Center
			St. Helena	Auxiliary
28	Yolo	39,400	Woodland	Health Center
			Davis	Auxiliary
			Winters	Auxiliary
29	Solano	129,300	Vallejo	Health Center
			Fairfield	Auxiliary
			Dixon	Auxiliary
			Benicia	Auxiliary
30	Sacramento	201,500	Sacramento	Health Center
			North Sacramento	Auxiliary
			Isleton	Auxiliary
31	Contra Costa	298,300	Martinez	Health Center
			Pittsburg	Auxiliary
			Richmond	Health Center
			Antioch	Auxiliary
			Walnut Creek	Auxiliary
			El Cerrito	Auxiliary
32	San Joaquin	193,400	Lodi	Auxiliary or Health Center
33	Alameda	708,800	Oakland	1 Health Center 4 Auxiliary
			Berkeley	1 Health Center 2 Auxiliary
			Alameda	Health Center
			San Leandro	Auxiliary
			Hayward	Auxiliary
			Centerville	Auxiliary
			Pleasanton	Health Center
34	San Francisco	827,400	San Francisco	5 Health Centers 6 Auxiliary facilities
35	San Mateo	171,100	Daly City	Auxiliary
			San Mateo	Health Center
			South San Francisco	Auxiliary
			Burlingame	Auxiliary
			Redwood City	Health Center
			Half Moon Bay	Auxiliary
36	Santa Cruz	47,200	Santa Cruz	Health Center
			Watsonville	Auxiliary
37	Santa Clara	224,400	San Jose	Health Center
			Sunnyvale	Auxiliary
			Los Gatos	Auxiliary
			Palo Alto	Auxiliary
			Gilroy	Auxiliary
38	Stanislaus	100,900	Modesto	Health Center
			Oakdale	Auxiliary
			Turlock	Auxiliary
39	Merced	59,100	Merced	Health Center
			Los Banos	Auxiliary
			Gustine	Auxiliary
40	Madera	33,300	Madera	Health Center
41	Fresno	231,600	Fresno	Health Center
			Coalinga	Auxiliary
			Reedley	Auxiliary
			Mendota	Auxiliary
42	Kings	43,600	Hanford	Health Center
			Corcoran	Auxiliary
			Lemoore	Auxiliary
			Avenal	Auxiliary
43	Tulare	125,500	Visalia	Health Center
			Porterville	Auxiliary
			Dinuba	Auxiliary
			Tulare	Auxiliary
44	Alpine	300	No construction recommended	
45	Mono	2,400	Bridgeport	Auxiliary
46	Inyo	10,700	Bishop or Independence	Health Center
47	San Benito	14,300	Hollister	Health Center
48	Monterey	95,200	Salinas	Health Center
			Monterey	Auxiliary
			King City	Auxiliary
49	San Luis Obispo	49,700	San Luis Obispo	Health Center
			Paso Robles	Auxiliary
			Arroyo Grande	Auxiliary
50	Santa Barbara	86,200	Santa Barbara	Health Center
			Santa Maria	Auxiliary
			Lompoc	Auxiliary
51	Kern	171,000	Bakersfield	Health Center
			Inyo-Kern	Auxiliary
52	Ventura	124,200	Ventura	Health Center
			Oxnard	Auxiliary
			Santa Paula	Auxiliary
53	San Bernardino	208,400	San Bernardino	Health Center
			Ontario	Auxiliary
			Needles	Auxiliary
			Redlands	Auxiliary
			Victorville	Auxiliary
			Barstow	Auxiliary
54	Riverside	139,000	Riverside	Health Center
			Indio	Auxiliary
			Blythe	Auxiliary
			Palm Springs	Auxiliary
			Corona	Auxiliary
			Banning	Auxiliary

PROPOSED PUBLIC HEALTH CENTER AND AUXILIARY FACILITIES—Continued
California, 1948

	County	Estimated population*	Proposed facility	
			Location	Type
55	Imperial	61,600	El Centro	Health Center
			Calexico	Auxiliary
			Brawley	Auxiliary
56	Orange	181,100	Santa Ana	Health Center
			Balboa	Auxiliary
			Fullerton	Auxiliary
			San Juan Capistrano	Auxiliary
			Seal Beach	Auxiliary
57	Los Angeles	3,566,200	Los Angeles City	6 Health Centers
				8 Auxiliary facilities
			City of Long Beach	1 Health Center
				2 Auxiliary
			City of Pasadena	Health Center
			City of Beverly Hills	Health Center
			Area served by Los Angeles County Health Department	8 Health Centers
				10 Auxiliary facilities
58	San Diego	552,800	San Diego	1 Health Center
				3 Auxiliary
			Jacumba	Auxiliary
			Pomona	Auxiliary
			Julian	Auxiliary
			El Cajon	Auxiliary

* Population estimated by the California State Department of Public Health in connection with the allocation of funds under Chapter 1562, Statutes of 1947.

Mental Health—A World Problem

Most people in the field of public health who are looking for words to express an idea that seems new, sooner or later find that one man has already said it, and said it better than most of us could ever hope to.

Here is a quotation run as a filler in the *Weekly Bulletin* of this department on December 29, 1928. The author is C. E. A. Winslow.

"A healthy national mentality does not look for war: for are not all wars reactions to buried conflicts? The bringing of these conflicts to the surface, the digestion and disposal of them, is the art of making peace. Mental hygiene is concerned with the causes of war and its message to peace workers is a message of hope—hope in the understanding of human personality—in the understanding of the fears, aspirations, strivings and tendencies that operate consciously in all human behavior, in industrial and group relations."

Examination Announcement

An examination for the position of *Associate Sanitary Engineer* has been announced by the State Personnel Board. Final date for filing application is May 22d. Examination date is June 12th.

Further information concerning this examination may be obtained from the State Personnel Board, 1015 L Street, Sacramento. Applicants are reminded that a new application form, No. 678, has replaced the form previously in use.

Here's An Invitation to the Health Education Conference

All Californians attending the Western Branch American Public Health Association meeting in Salt Lake City are cordially invited to participate in the one-day health education conference which will be held on May 24th the day before the first general session of Western Branch.

Last year's health education meeting in San Francisco was highly successful and attracted individuals from all fields of public health. This year's meeting promises to be equally interesting with a series of discussions of health education problems and programs.

5,500 X-Rayed in First Year of S. F. Chinatown Survey

The densely populated Chinatown area of San Francisco has presented a complex tuberculosis control for many years. Tuberculosis morbidity rates in this comparatively small section of the city have been significantly higher than those in the city as a whole for many years.

In March of 1947, community leaders, private physicians, the local health department, local tuberculosis association and the State Department of Public Health instituted a cooperative casefinding program in an attempt to help solve the problem. A miniature X-ray machine loaned to the tuberculosis association by the State was set up in the Chinese Hospital.

Private physicians referred their patients to the center and the San Francisco Health Department undertook follow-up examinations on individuals who came for examination without referral.

In the first 12 months of the program, March, 1947, through February, 1948, a total of 5,500 miniature chest X-ray films were taken. Of this number, 261 needed further study. To date, a total of 71 active cases have been discovered. Seventeen of this number have been hospitalized.

To cause the citizen to do the things he can and ought to do, and then to do for him the things he cannot do, but which should be done, is the duty of the state.—*Eugene H. Porter, M.D., New York State Health Commissioner, 1905-1914.*

In the health of the people lies the strength of the nation.—*Gladstone.*

Importance of Vaccination Emphasized In Saga of Rabid Dog *

It is improbable that many persons fully appreciate the true extent of the danger surrounding a rabid dog. Improbable, too, that enough of us realize the territory a rabid dog may cover and the damage he may do, impelled by the effects of his disease.

The report of the activities of one such dog circulating swiftly through three townships of southeastern Chenango County, in New York State, attacking three children and six other dogs on the way, should serve to emphasize the need for prompt and drastic action when dealing with rabid or potentially rabid dogs.

This dog, a stray, traveled along the south bank of the Susquehanna River. On the outskirts of the village of Afton he bit a puppy playing on the front porch of a farm home. Continuing for a short distance down the road, he paused briefly at a second home where two dogs were playing in the dooryard. Here no harm was done.

When the rabid animal was next observed he was on the other side of the Susquehanna River headed in a direction opposite from his original course. In Bainbridge the police chief reported having seen a stray animal approach a street intersection, wait for traffic, and then proceed across the street.

Shortly afterwards the same dog molested a five-year-old boy at play on the porch of his home near by. The animal then proceeded to the next house—the home of the police chief. Here he bit the family dog so severely that it had to be destroyed. At the next stop, some distance down the road, a 16-year-old boy was bitten.

From Bainbridge the trail of the rabid dog took him to the porch of a house in West Bainbridge where the characteristics of his disease led him to bite and tear apart the porch furniture. Continuing his steady travel, another characteristic of one form of rabies, he attacked a Collie dog at the next house. This dog also was destroyed as a precautionary measure against the possible spread of the disease.

Another Dog Bitten

Passing into the town of Coventry, the rabid animal bit another dog there. Later the owner of the bitten dog took him to a vaccination clinic where it was found that dumb rabies had developed. At the next house a fight took place between the rabid dog and the pet dog of that home. Only earlier vaccination saved the life of the dog attacked. The dogs at the next house escaped only because they had been removed from the yard to the cellar a few minutes before.

The twelfth stop of this stray animal and his attack on the dog there prompted the owner to pick up his gun. By the time he reached the scene, however, the intruder was once more on his way down the road. The owner of the attacked dog gave chase in his car, but snow drifts prevented him from overtaking the rabid animal. Finally, freeing his car from the ice and snow, he turned around and, by taking a circuitous route, approached the road traveled by the rabid dog from another direction. When he arrived at the place of the dog's thirteenth visit, he found that a bullet had at last ended the misery of the dog himself and the peril to those in his path. The head of this dog was submitted for laboratory examination and a diagnosis of rabies made.

Aside from the direct effects of this stray dog's condition, there was at least one serious indirect effect. About two weeks after the first dog was bitten his owner noticed that he was becoming irritable. Subsequently he bit one of the children of the family. Because of this dog's Chow-Spitz ancestry, his action was not considered particularly significant. Later, however, this same dog bit a neighbor three times. After this incident, he was confined in the cellar. When his owner offered him food he became so ferocious that she gave up the attempt and called a neighbor. This dog, too, was finally destroyed and his head submitted to the laboratory where examination proved positive for rabies.

The record of this rabid dog, ownership and origin unknown, strongly emphasizes the need for effective rabies control measures in all areas. All of the dogs bitten were on the property of their owners at the time, but this did not protect them against attack by a stray rabid dog. Of the animals not immediately destroyed, two of those bitten are known to have developed rabies. Neither of these two had been vaccinated because they were too young at the time the opportunity was offered a year previous.

This story points out the necessity of owner education in addition to compliance with the law in the matter of dog management, where local rabies control regulations have been passed. It also makes one wonder if it would not be wise to vaccinate dogs under six months. A notation could then be made on the vaccination certificate advising the owner to have the dog vaccinated again some time before he reached one year of age.

We see the weakness and credulity of men is such that they will often prefer a mountebank or witch before a learned physician.—*Lord Bacon.*

* Reprinted from *Health News*, April 12, 1948. This publication is issued weekly by the New York State Department of Public Health.

Experiments In Changing Food Habits

If the dissemination of facts were enough to change behavior, the problem of health education (and a hundred other fields) would be absurdly simple.

Unfortunately this is not the case, although we find evidences of this type of thinking in many school and public health education attempts. Changes in behavior occur when emotional responses of the individual to an educational program motivate him to use the information which is presented.

Just how changes in behavior can be brought about in situations similar to those encountered in community health education programs has been the subject of several experiments during recent years.

A recent experiment, conducted by Marian Radke and Dayna Klisurich * was undertaken to investigate the relative effectiveness of group decision, lecture, and individual instruction methods in changing food habits.

Group decision in this case is differentiated from group discussion in this way: "although in both there is a free exchange of ideas and in both a certain amount of initiative taken by the group, group decision, unlike discussion, leads to the setting up of definite goals for action; and these goals tend to be stabilized by group decision in a way which carries the individual through to action."

The study covered two fields of nutrition education: infant feeding and family milk consumption.

Infant Feeding

In the infant feeding program the mothers in the maternity ward of a hospital were divided into two groups of similar composition. One-half of the mothers (Group A) received the usual instructions on infant feeding consisting of a printed schedule and a 15-20 minute interview with a dietitian.

Group B was divided into three sections of six persons each. The dietitian met informally for about 20 minutes with each group in the ward to discuss infant feeding. The method used to bring the mothers to a group discussion is described as follows:

> Maintaining a friendly and informal atmosphere, she emphasized the importance of diet for the infant's welfare and the difficulty which hospitals experience in getting mothers to carry out instructions. She asked these mothers to suggest better methods of getting mothers-in-general to follow the dietary instructions and the mothers gave suggestions freely. The discussion gave them the opportunity to ask questions and to bring up difficulties which they anticipated or had experienced with other children. The leader inquired about their experiences in feeding cod-liver oil and orange juice, the methods they had used, and how effective their methods had been. Thus the mothers were led to see the problems concretely and to see how difficulties could be met. As the mothers brought up specific problems, other mothers or the dietitian were able to offer solutions.
>
> During the discussion, the dietitian explained the diet schedule given each mother, emphasizing the amounts of cod-liver oil and orange juice which the baby should have every day and restating the importance of these supplements. This was the same technical information given in the individual instruction setting. When some group feeling had been developed through shared ideas and shared experiences, the leader returned to the question: how could hospitals motivate mothers to follow instructions in feeding of infants? The leader asked whether the group felt that mothers-in-general would benefit from discussions and would be aided by them in following hospital advice. The mothers readily agreed and added further suggestions and modifications. By attributing cooperative behavior to other mothers in situations similar to their own, these mothers were brought close to a decision to carry out hospital instructions themselves, although they were not yet explicitly involved in the decision.
>
> The leader then summed up what they had accomplished and raised a query as to their own willingness to carry out the dietary instructions. The suggestion was accepted in each of the three groups and their decision to follow hospital instructions was made articulate and explicit by the group members. In each group the decision was unanimous.

Second Experiment

In the second experiment, the group decision and lecture methods were compared. In one case, a lecture on the nutritive value of milk was given to groups ranging in size from six to nine. Meetings leading to group decision similar to the infant feeding meeting described above were held with other groups of the same size and composition.

In both experiments, follow-up investigations showed that the group decision method was significantly more effective in motivating mothers and housewives to action than were either individual instruction or lecture methods.

This study and others like it are of great importance in all phases of health department work. Because it has not been possible to discuss this experiment in more detail, interested readers are referred to the original article and the reference cited in it. Reprints are available from the American Dietetic Association, 620 North Michigan Avenue, Chicago, Illinois.

* Marian Radke and Dayna Klisurich, "Experiments in Changing Food Habits." *Journal American Dietetic Association*, 23:403-409, May 1947.

Department Accepting Applications for Hospital Construction Funds

Applications for federal and state aid to build new hospital facilities or improve existing facilities will be accepted from now until July 15th by the State Department of Public Health.

Nearly $4,000,000 in state and federal matching funds will again be available in the new fiscal year beginning July 1st. Plans for community building programs should be submitted as soon as possible for study by this department. Requests for assistance may be submitted by any non-profit hospital district or organization, whether private or public. However, institutions not supported by public taxation may draw only on the $2,000,000 in federal money appropriated for the construction program.

The Department's Bureau of Hospitals will assign priority claim on available funds chiefly on the basis of each community's need for adequate, accessible hospital facilities, its population and financial resources.

Mrs. Fred T. Foard

The wife and the sister-in-law of Dr. Fred T. Foard, formerly of the San Francisco district office, U. S. Public Health Service, were killed in their home in San Juan, Puerto Rico, when a leaking gas tank caused an explosion which completely wrecked the house. Dr. Foard himself suffered a badly dislocated ankle and a fractured leg.

Manual Evaluating VD Educational Material Issued

"A Guide for Selecting Venereal Disease Education Materials" is now at the disposal of local health departments.

The manual, titled "VD Education Materials, 1947-48; A Guide to Selection Based on the Evaluation of Available Items by a National Committee," may be obtained from the Venereal Disease Education Institute, Raleigh, North Carolina.

The title is fairly descriptive of the publication, which was produced in cooperation with the U. S. Public Health Service and other interested groups.

Doing a job for which there is an ever-increasing need, the evaluation committee has taken a wide variety of venereal disease education materials in use throughout the country and analyzed each as to uses in community health education programs.

Here is evaluation in a real situation, presented in a positive and functional manner. Should be a "must" for every public health department.

International Mental Health Congress To Meet

The International Congress on Mental Health will convene in London, August 11-21, 1948.

Attention at the meeting, which will bring together outstanding psychiatrists, psychologists, sociologists and others from all parts of the world, will focus interest not primarily on the problems of individuals but "more on the wider problems of a sick society, since at the moment this seems particularly appropriate."

Further information may be secured from the International Committee for Mental Hygiene, Inc., 1790 Broadway, New York 19, New York.

Some Factors to Consider in Adult Education Programs

Any adult education program in health or any field, must be built around factors growing out of the sociology of adults. This is the opinion of Dr. Wilbur C. Hallenbeck, Professor of Education, Columbia University Teachers College, and a well-known leader in the field of adult education.

Because of its application to community health education programs, Dr. Hallenbeck's statement of the points to consider, which appeared in the *Adult Education Journal*, * are reprinted here:

1. The community is the setting of any adult education situation and determines the kind of adults who will participate, the problems they will have, the character of activities involved in the solution of these problems, and the adult education possibilities.

2. The motivation on the part of adults for educational experience is closely related to the problems which they encounter in daily living. Their educational opportunities should therefore take account of these problems.

3. Since it is the pressure for action which is the focus of experience motivation, the completion of the educational experience for adults involves action.

4. The aim of adult education must be the satisfaction of the adult participants, not the completion of a course of study or a term of classes.

5. Since the world of experience of the majority of adults is very limited, in our present day with its great opportunities for the enrichment of living, adult education has the obligation of "expanding the horizons" of adults.

6. Growth into effective democratic citizenship is an adult education process.

* Wilbur C. Hallenbeck, "Training Adult Educators," *Adult Education Journal*, 7; 4-13 (January 1948).

Annual Count of Public Health Nurses Shows Increase

At least 134 more nurses were engaged in public health work in California as of January 1, 1948, than the same date last year, according to results of the annual count of public health nurses recently tabulated by the Department's Bureau of Public Health Nursing.

Twenty-eight more official agencies reported public health nurses on their staffs in the present survey as contrasted with the one concluded January 1, 1947. Three of these were newly organized health departments; the remainder were boards of education.

The need for more and better qualified nurses to serve the State is still great. Accepting a ratio of one nurse to 5,000 population as the lowest to maintain minimum services, California has a variance of from one nurse to 17,800 people in one of the more sparsely settled counties to one nurse in 3,000 in a more densely populated coastal area. Three counties, out of the State's 58, are still without public health nurses. One other county has a nurse for the Indian population *only*.

Industrial nurses at work in California in 1948 increased only slightly over 1947.

Highlights of the annual count of nurses for the past three years are tabulated below.

	1948	*1947*	*1946*
Public Health Nurses			
Total number of agencies employing public health nurses	384	356	337
Total number of nurses engaged in public health nursing in California	1,766	1,632	1,507
Total number of nurses included in survey	1,689	1,547	1,397
Percentage of nurses from whom information was received, who have completed a university program of study in public health nursing	39.2	35.2	35.4
Industrial Nurses			
Total number of industries employing nurses	295	300	238
Total number engaged in industrial nursing	533	530	383
Total number of nurses included in survey	299	313	319
Percentage of nurses from whom information was received who have had some university training in public health or industrial nursing	21.0	22.4	21.6

Dr. Morgan Visits California

Dr. Lucy Morgan, Professor Health Education at the University of North Carolina, recently concluded a brief trip to California.

Dr. Morgan came west to inspect the field training station at the San Jose City Health Department where two of her students are now being given practical experience in community health education. During her brief stay, Dr. Morgan met with health educators in Northern and Southern California.

Dr. Noel Keyes

Dr. Noel Keyes of the University of California, who has gained national recognition in the family life education field, died of a heart attack while on a lecture tour in Utah.

The six-week Institute of Family Life which Dr. Keyes was to conduct at the University of California in Berkeley this summer will be held as scheduled under the direction of Dr. Ralph Eckert of the State Department of Education.

Q Fever Organism Reclassified

Coxiella burnetti is the new designation which has been given to the causative agent of Q fever. Originally, the microbe was labeled *Rickettsia burnetti*, but recent studies have indicated that it is not actually a rickettsial body, but belongs to a related but different genus.

The Q fever agent is the first to be classified in this group. The word "Coxiella" is derived from the name of Dr. Herold R. Cox, who, as a member of the Rocky Mountain Spotted Fever Laboratory, was among the first in the United States to isolate the agent later discovered to be that of Q fever.

New U.S.P.H.S. Appointments

The U. S. Public Health Service has announced the appointment of Dr. John R. Heller as Director of the National Cancer Institute succeeding Dr. Leonard A. Scheele, the new Surgeon General.

Dr. Heller has been chief of the Division of Public Health Service's Venereal Diseases since 1943. Dr. Theodore J. Bauer will now take over this post. Dr. Bauer was formerly venereal disease consultant for the Public Health Service at the San Francisco district office and more recently has been serving as venereal disease control officer for the Chicago Board of Health.

Do You Want Your Pamphlets to Pull? —Then See This

If your agency is concerned with the problem of producing effective printed pamphlets, the latest publication in the National Publicity Council's "How-To-Do-It" series is the book for you.

Pamphlets That Pull is the title; Alexander Crosby, the author; $1, the price.

Whatever the purpose of your pamphlet—education, promotion, or action, *Pamphlets That Pull* should prove helpful to you in catching and holding reader interest.

Most of the questions continually besetting the pamphlet producers are answered by Mr. Crosby. Writing style, designing, type faces, fitting material to the pamphlet, cost of printing, and other topics are discussed in a simple and practical manner.

Pamphlets That Pull should be ordered directly from the National Publictiy Council, 130 East 22d Street, New York City, N. Y.

Barstow Under County Supervision

The City of Barstow in San Bernardino County is now under the health supervision of the county health department. Barstow was incorporated in November of 1947.

Other communities to come under the supervision of a county health department recently were the cities of San Juan Bautista and Hollister in San Benito County.

"On the broad and firm foundation of health alone can the loftiest and most enduring structure of the intellect be reared."—*Horace Mann (1845).*

If any one thing, however, has been settled in this realm of thought by unison of opinion, it is the statewide extension of the interest in the maintenance of life and health. The advancement of that interest, like the advancement of education, is the function of the state at large.—*Justice Cardozo.*

"Education has no more serious responsibility than making adequate provision for enjoyment of recreation and leisure; not only for the sake of immediate health, but still more if possible, for the sake of its lasting effect upon habits of the mind."—*John Dewey (1915).*

Selected Diseases—Civilian Cases

Total Cases for March and Total Cases for January Thro March 1948, 1947, 1946 and 5-Year Median (1943-1947)

Selected diseases	Current month				Cumulative			
	March				January through March			
	1948	1947	1946	5-yr. median 1943-1947	1948	1947	1946	
Chickenpox (varicella)	7,553	6,487	3,875	6,739	16,010	15,714	9,568	
Coccidioidal granuloma	9	3	8	----	13	12	13	
Conjunctivitis—acute infectious of the newborn (ophthalmia neonatorum)	----	2	5	----	4	4	12	
Diphtheria	70	74	109	111	182	306	397	
Dysentery, bacillary	28	14	23	----	74	34	57	
Encephalitis, infectious	2	4	5	5	8	13	10	
Epilepsy	222	137	141	----	524	439	397	
Food poisoning	8	16	9	----	25	116	106	
German measles (rubella)	607	311	2,526	----	1,032	674	4,820	
Influenza, epidemic	1,502	205	437	272	13,645	362	4,870	
Jaundice, infectious	11	9	16	----	26	32	59	
Malaria	2	8	79	8	12	31	274	
Measles (rubeola)	10,785	981	12,633	4,676	16,536	2,482	23,269	
Meningitis, meningococcic	48	28	55	87	147	96	235	
Mumps, (parotitis)	4,191	2,170	2,553	3,930	8,487	5,369	7,311	
Pneumonia, infectious	163	173	301	394	558	674	1,011	
Poliomyelitis, acute anterior	24	44	24	20	46	173	98	
Rabies, animal	43	26	30	61	105	79	102	
Rheumatic fever	108	68	55	----	249	214	190	
Scarlet fever	479	628	840	840	1,290	1,861	2,911	
Streptococcic sore throat	56	86	----	----	189	184	----	
Smallpox (variola)	----	1	4	1	----	2	7	
Tuberculosis: Pulmonary	838	603	565	603	2,093	2,074	1,744	
Other forms	64	58	26	44	143	142	100	
Typhoid fever	7	10	14	14	35	18	33	
Typhus fever	1	1	6	----	3	10	14	
Undulant fever (brucellosis)	11	19	21	19	33	53	71	
Whooping cough (pertussis)	596	750	373	750	1,411	1,765	1,411	
Venereal Diseases: Chancroid	62	68	34	----	126	179	100	
Gonococcus infection	2,653	2,493	2,421	2,283	6,879	8,424	7,650	
Granuloma inguinale	6	12	3	----	15	23	6	
Lymphogranuloma venereum (lymphopathia venereum, lymphogranuloma inguinale)	35	17	12	----	76	60	49	
Syphilis	1,910	1,956	1,952	2,400	4,613	6,461	6,011	

Dr. Belt to Lecture in Switzerland

Dr. Elmer Belt of Los Angeles, member of the St Board of Public Health, has been invited to Swit land to present the Annual Urological Address.

During his trip, Dr. Belt will also discuss urol problems with students at Johns Hopkins in Balti and the Bellevue Hospital in New York.

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